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The Specific Duty of the M.O.H. in Communicable Diseases

By Dr. Jas. Roberts

THE communicable diseases with which the Medical Officer of Health is chiefly concerned in Ontario are Smallpox, Typhoid Fever, Diphtheria and Septic sore throat, Scarlet Fever, Measles, Whooping Cough, Pneumonia, Mumps, Chickenpox, Tuberculosis, with sporadic outbreaks of Anterior Poliomyelitis, Cerebro Spinal Meningitis and Influenza. He is also charged with the administration of the V.D. Act.

In a general way the responsibility of the M.O.H. with respect to the control of these diseases is defined in Sect. 57 of the revised Public Health Act which reads as follows;—Where any communicable disease is found to exist in any municipality, the medical officer of health and local board shall use all possible care to prevent the spread of infection or contagion by such means as in their judgment is most effective for the public safety.

The specific measures undertaken by the health officer in the control of the epidemic diseases should be governed as far as possible in accordance with known knowledge, first, as to their mode of origin, and second as to the manner of their dissemination.

In order to be as brief and concise as the subject will permit, I propose to begin at once with smallpox, by reminding you of that with which you are quite familiar, the disquieting effect on the tranquillity of the health officer occasioned by the appearance of this disease in his community. The Ontario Vaccination Act requires the successful vaccination of every child born in the Province within four months after the birth of the child, either by the family physician or by a legally qualified practitioner appointed by the local board of health or the municipal council for this particular duty, and at a convenient place appointed by the municipal council, or in default of the appointment of such place, at a place

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appointed by the local board of health. If smallpox exists, or there is danger of an outbreak owing to inter-communication with an infected locality, it is the duty of the municipal council to order general vaccination or revaccination as the individual may require. The presence or threatened presence of smallpox in a community empowers the medical officer of health to demand evidence of successful vaccination or revaccination, within a specified time, of all pupils or students in attendance at elementary and high schools, colleges and universities or any other private or public institution of learning within his jurisdiction. The trustees, governors or directors having control of a hospital or dispensary receiving government aid are required to keep on hand at all times a supply of smallpox vaccine, to vaccinate poor persons free of charge and such others as are able to pay, for a fee not exceeding fifty cents. A certified statement by the proper officials of such hospitals or dispensaries, showing the number of persons who have applied for and received free vaccination, also a list of those who have paid for this service and the monies received therefor and how applied is required annually by the government. Contravention of any of the requirements of the Vaccination Act incurs the penalties set forth therein. Nevertheless its provisions are more honored by their neglect than their observance. Statistics tell us that for some years past, smallpox, is on the increase in both the United States and Canada. The Metropolitan Life Insurance Co., in response to a questionnaire sent out in 1921, elicited information with regard to the prevalence of variola in 243 cities of the United States and Canada. In 140 of the cities there were 14,335 cases of smallpox in 1919 and 154 of these cities reported in 1920, 19,104 cases of smallpox. The United States cities reported an increase from 42 to 58 per 100,000 of population in 1920. The Canadian cities showed an increase in their records from 150 to 165 per 100,000 of population between 1919 and 1920. The Surgeon General U.S. Public Health Service stated that for 1924, approximately one fifth of all the cases of smallpox reported in the world during 1923-1924 occurred in the United States. Detailed studies of this disease show that its incidence bears a very definite relation to the number of unvaccinated people where areas of any considerable size and population are considered. For instance Massachusetts, with good vaccination laws, had 457 cases during 11 years. Minnesota with no law, during the same period, had 35,153.

The anti-vaccinationists aver that the so called smallpox is not the pestilence of prevaccination days at all and is scarcely worthy of serious consideration. Their contentions assume an almost ludicrous turn in face of the fact that the first case in the Windsor epidemic was one of the haemorrhagic type and the Duluth outbreak in February 1924 began with the same type. The Detroit outbreak in 1924 showed that while

those exposed to discreto smallpox usually contract the disease in this form, a number of the secondary cases may be either confluent or haemorrhagic.

In my opinion, the Windsor, Detroit and Duluth epidemics have done much to discredit the propaganda of those opposed to vaccination in this country, and to expose the ignorance and fanaticism of their campaign. Every health officer in Ontario knows that vaccination protects against smallpox. He knows as a matter of experience that the people among whom it is seldom found are doctors and nurses, usually well vaccinated, and immigrants from foreign countries where vaccination is compulsory and systematically carried out. He knows that when asked over the phone by a fellow physician to see a suspicious smallpox rash, that invariably the first question he asks that physician about his patient is, "has he a vaccination scar?" If the answer is yes, he makes a provisional diagnosis of chickenpox always before seeing the patient.

What is the most successful, as well as practical, method for the control of this disease under present conditions? Vaccination by compulsion alone, quarantine and isolation alone, or a combination of optional vaccination with quarantine and isolation?

At a public health meeting over which I once had the honor of presiding, Dr. Herbert Sinclair of Walkerton said, "Owing to the ideas of personal liberty prevailing in Ontario, it would be as easy to enforce compulsory circumcision or infant baptism as compulsory vaccination (though you can enforce a law to make it a crime to buy a stamp, a newspaper or an ice cream soda on Sunday.)" and there is much to the point in his remarks.

In the presence of outbreaks of such fearful virulence as occurred in Windsor, Detroit and Duluth, health officers need not worry about the enforcement of vaccination. His greatest concern in such situations would appear to be the provision of facilities for carrying out the procedure on a scale sufficiently large to satisfy the public demand.

Perhaps the most important point in the control of the outbreaks of mild smallpox which have occurred so frequently in recent years in Ontario is the prompt recognition of the first cases. The incorrect diagnosis of these on the part of the attending physician puts the health officials of the community at a serious disadvantage, inasmuch as they may find themselves confronted with a considerable number of secondary cases, many of them so mild and hard to recognize, that the disease becomes difficult to control. On the first appearance of such an outbreak, it is the duty of the health officer to insist that all cases including those of a suspicious nature shall be promptly reported. Nurses and sanitary inspectors in the course of their routine work and house to house visiting,

should constantly be on the look out for mild and missed cases, some of which may not have had the attendance of a physician. Isolation in a suitably equipped hospital is desirable in this disease, especially for the more severe cases. All contacts should be quarantined for the period of incubation unless satisfactory evidence of recent successful vaccination or of immunity to the vaccine disease is obtainable. As the vaccination and mild smallpox not infrequently run concurrently there should be frequent observation of all vaccinated contacts during the incubation period.

All articles of clothing, bedding, and other materials surrounding the patient should be boiled and there should be an effective cleaning and disinfection at the termination of the illness.

The health officer should encourage by every educational means available, the vaccination of infants and young children, the vaccination or revaccination as the child may require of all school children, and, particularly where an outbreak assumes a severe or malignant type the immunization by this means of the adult members of the community.

There is no field of public health activity where the trained epidemiologist has a better opportunity for the display of his resourcefulness and capability than in the control of typhoid fever. The catch as catch can methods formerly employed to check the spread of this disease, like the shot gun prescriptions of the old time doctor deserve perhaps a not more distinguished memorial than to be classified with the anomalies and curiosities of preventive medicine. The health officer or his trained assistant who goes about investigating the source of typhoid fever to-day does not spend his time in useless speculation. With as complete a list as possible of the known cases in his possession, he obtains as speedily as he is able, the time of onset for the first case visited, and from this initial information he is able to secure approximately the time when infection took place, also the source or sources of his milk supply, drinking water, foods eaten, and his probable association with others who have been sick. This knowledge coupled with similar information with regard to one, two, or half a dozen other cases under investigation will probably lead him to certain coincidences in the histories obtained with respect to some of the items inquired into and dissimilarities concerning others. If the milk supplies used by the primary cases under consideration have been the same, milk, as the origin of the outbreak remains a possibility, but if the milk supplies have been different, milk as a causative factor, with certain exceptions where two or more supplies enter into the calculation, can safely be eliminated. Investigations can be made, and appropriate conclusions reached in a similar way with reference to the water supply of the patients. If the cases all originated in one particular section of a

city or town, the inhabitants of which are all supplied from a common reservoir, the water supply can with comparative certainty be eliminated from suspicion. I cannot do more in the time at my disposal than to give these one or two examples, illustrative of the method used by the epidemiologist in going about his work. To suggest in detail the number and complexity of the situations which may present themselves for his consideration and which it is his duty to untangle and to arrange in their true relationship and the order of their significance to the problem he has in hand cannot be attempted.

It is not sufficient for the trained investigator that a probable route of infection be indicated, and the circumstantial evidence made to tally with his tentative findings. It is his duty, in incriminating a water supply, a milk supply, or other cause as the source of typhoid fever, and more especially in view of recent decisions handed down by the courts of this province with respect to the liability of municipal corporations for the payment of damages by neglecting the prevention of typhoid, to make sure that his findings are correct, that they are consistent with all the facts he has been able to bring to light, and that they establish beyond possibility of reasonable doubt, the responsibility of the cause to which the disease has been ascribed, as the true and primary cause of an outbreak.

Once the main route of an epidemic of typhoid is discovered the measures to be adopted for its control are definite, easily understood and not difficult of application. The patients should be isolated, preferably in a hospital, in a fly proof room if a proper sanitary environment cannot be provided in the home, and nursing care cannot be afforded by the patient. Release from isolation should not be considered safe until two successive negative cultures of stools and urine, and collected not less than 24 hours apart, have been tested at the laboratory. All those in the family of the patient who have been exposed, and contacts among friends and visitors should be promptly immunized with appropriate doses of typhoid vaccine. Bowel and urinary discharges and articles soiled with them, should be subjected to concurrent disinfection. By concurrent disinfection is meant the application of disinfection immediately after the discharge of infectious material from the body of an infectious person, or after the soiling of articles with such infectious discharges, and the prevention of personal contact with such discharges or articles prior to their disinfection.

Outbreaks of typhoid fever like the recent epidemic in Montreal are a tragic object lesson of how our knowledge with respect to the prevention of a highly fatal disease can be discredited, by lack of ability to apply, for one reason or another, such knowledge in the face of an impending disaster. The general measures for the prevention of typhoid fever have been reiterated times without number. The necessity for the protection and

purity of public water supplies and pasteurization of milk supplies, cannot be too strongly nor too frequently insisted upon, the supervision of food supplies and food handlers, the prevention of fly breeding, the supervision of typhoid carriers, the sanitary disposal of human excreta and the immunization by vaccination in communities where the disease is prevalent, are important factors in the control of this disease. As the result of my experience of 22 years with typhoid fever in Hamilton, I would lay special stress on the strict prohibition of going in and out of houses where typhoid exists. Sanitarians have been slow, in my opinion, to realize the ready communicability of typhoid germs from sick to well persons. The transference of the virus from the patient or his surroundings to fingers, and from fingers to mouth of those in a state of susceptibility, is an easy and common mode of infection, and should never be forgotten. Typhoid fever is a contagious disease, and its eradication cannot be successfully accomplished until it is treated accordingly.

The control of diphtheria until the work of Park, Zinger and Schroeder in the schools of New York City became generally accepted, was one of the most perplexing problems of the health officer. Until the results of their work became known, there was a steady increase in the case incidence, although the case fatality due to the almost universal use of antitoxin, was diminishing. The mild cases which play so important a part in the spread of epidemics, notwithstanding the provision of laboratory facilities for diagnosis, and the employment of school and public health nurses for the finding of these cases, continued to escape detection. In spite of our laboratory knowledge of the specific organism, methods of isolating carriers of either temporary or more permanent types, and of attempting to effect the disappearance of the persistent organisms from the noses and throats of those harboring them, were of little avail. We do not know the mechanism of development of the carrier state, we do not know accurately the number of carriers in the community, and the practical difficulties in the way of seeking out and finding these carriers, economic and otherwise, have been sufficient to counterbalance any tangible and beneficial results obtained. For instance Perkins, Miller and Ruh in Cleveland made records during three years concerning the length of quarantine in 4,853 houses. The average length of quarantine was 20.5 days, and the release cultures became negative in periods varying from 3 to 90 days. A few of the cultures were positive after 90 days. Wadsworth in 380 convalescent carriers found 337 or 88.6 per cent virulent. Bullock and others took 610 cultures from close contacts in institutions, barracks and hospital wards, 93 were positive morphologically of which the entire number were virulent. In 10,833 cultures from infected houses they found 892 or 8 per cent positive, and of these, 866 were virulent.

These figures indicate in their opinion, "That when the contact is close the number of infected persons is high, and that practically all strains of the bacillus diphtheria, isolated from contacts, are virulent." Goldberger, Williams and Hacktel of Detroit found that about one in 100 cultures, taken from the general population of the city, showed the diphtheria bacillus, and of these one in 10 were virulent. Bull, Havens, Doull and Phales found that in November and December the percentage of virulent carriers in the different school populations is 3.29; during February and March it is 1.49; during May and June it is 0.87 and during August it is 0.19. These findings from convalescent carriers, contacts, healthy non-contacts, and healthy school children give some idea of the difficulties presented by the carrier problem to the health officer of the more thickly populated communities, the danger of the convalescent to the public, and the necessity for his isolation. Isolation of the known cases until cultures from the nose and throat fail to show the presence of diphtheria bacilli, and the quarantine of exposed persons until bacteriological examination reveals them to be non-carriers, are important in the control of diphtheria, and while the search for the detection of carriers and the placing of restrictions upon these until a reliable estimate can be made on their ability to infect has a beneficial effect in the same direction, it is our opinion that the best and most practical method for the elimination of the disease is by the wide spread use of the toxin-antitoxin or toxoid.

For the five year period from 1905 when I became health officer of Hamilton until 1909 inclusive, we had 818 cases of diphtheria with 83 deaths, from 1910 to 1914, 691 cases with 70 deaths. From 1915 to 1919, 1001 cases with 116 deaths, from 1920 to 1924 inclusive, 2833 cases with 175 deaths.

In January 1922 an immunization clinic was established in the Health Centre where facilities were available for the work. The Board of Education gave its consent to carry on the work in the public schools and the medical officer, Dr. J. E. Davey gave his sympathetic assistance to our efforts. Since the commencement of our immunization campaign there have been approximately 16,000 children of school and pre-school age treated at the school and Health Centre clinics. In 1921 there had been 608 cases with 41 deaths, in 1922 we had 747 with 32 deaths, 1923, 381 cases with 26 deaths, 1924, 501 cases with 32 deaths, 1925, 232 cases with 14 deaths, in 1926, 121 cases with 3 deaths. For the first seven months of 1927 there have been 15 positive cultures reported from the laboratory and one death attributed to diphtheria, upon which a positive culture was not obtained, and our diphtheria hospital of 40 beds, for more than a year, has been practically depopulated. The result of the campaign, we think, justifies our statement to the public that diphtheria can with certainty be prevented, and that in a few year's time can be banished from the city.

The control of scarlet fever as in the case of diphtheria depends mainly upon two factors, first, the early recognition and isolation of mild cases, and second, the supervision for a sufficient length of time, of convalescents still harboring the scarlatinal streptococcus in the secretions of the mouth and nose or spreading the infection by means of running ears, abscesses or other discharges. In the past two years our knowledge of the cause and treatment of this disease has made greater strides than has been the case in any other contact diseases. An important point over which there has been an interminable amount of discussion, and about the relative importance of which epidemiologists have differed widely, has been settled in that the skin is no longer regarded as having a part in the conveyance of the infection. The scales during the period of desquamation are not the medium by which the spread of the virus takes place. It is now known that the mode of transmission is by the saliva or nasal secretions or by articles that have been soiled with such secretions and by discharges from secondary complications such as adenitis or middle ear disease. Unfortunately we have not, in this disease, as in the case of diphtheria, developed the laboratory detection of the specific organism in cases where it persists for long periods of time, to a degree which will enable us to maintain a supervision over these carrier cases which will be effective. Hence we frequently find especially in populous centres, that cases, when released from hospital, or from isolation in the home, and as far as can be ascertained by physical examination, entirely recovered, immediately infecting those around them. It would appear in fact that the persistence of virulent streptococci in these convalescent cases and in persons with such complications as otorrhoea and rhinorrhoea is the main factor in keeping scarlet fever alive through the summer months and giving rise upon the opening of schools in the autumn to the seasonal prevalence of the disease. Scarlet fever is not so readily communicated as diphtheria, measles, whooping cough or the minor communicable diseases and in the administrative control of the disease, the fact, that the incidence of infection after exposure is only about twenty to thirty per cent must be taken into consideration.

Clinical trials of the scarlet fever antitoxin in both hospital and private practice indicate that this new product is likely to be as important in the control of scarlet fever as antitoxin in diphtheria, and is one of the important recent advances in preventive medicine, but on account of the disease being much less readily communicable than diphtheria or smallpox, it is debatable whether hospitalization is to be generally advised for the milder cases. The fact which is well known to every physician of experience in handling contagious diseases, that many children exposed to scarlet fever and apparently susceptible do not take the disease has

been again called to the notice of the health officer by Dr. Clendennin in a paper appearing in the Medical Officer of June 5th, 1926. Dr. Clendennin reports that among a series of 107 cases of scarlet fever occurring in 96 houses, in 86 of these there was only a single case, in 9 houses 2 cases and in one house 3 cases. In the 86 houses where only single cases appeared there were 249 children in all under 15 years of age with a history of not having had scarlet fever. For 1924 and 1925 he made a study of the incidence rate in houses of from 1 to 8 rooms and compared this with the incidence rate for houses where cases were removed to hospital. The results of his observations during this period of two years did not indicate that crowding had any effect on the attack rate. Hospitalization of his cases was avoided as much as possible and removal advised only when effective treatment could not be carried out at home. The conclusions of Dr. Clendennin are confirmed by Dr. Garrett, Medical officer of health of Cheltenham who in an experience of 35 years finds that though opportunity for contact in the home may be easy, scarlet fever is often limited to a single case.

One of the most astonishing facts connected with the history of scarlet fever is the great fall in the mortality during the last 70 years. This is pointed out by Chapin in the annual health report of the city of Providence for the year 1925, where the death rates from 1856 to 1925 per 100,000 living are tabulated.

1856-1865	123.6
1866-1875	104.7
1876-1885	70.9
1886-1895	42.8
1896-1905	10.4
1906-1915	14.7
1916-1925	4.1

Before leaving the subject of scarlet fever it may be in order to say a word or two concerning the relationship of milk supplies to the control of typhoid fever, diphtheria, scarlet fever and septic sore throat to emphasize further the necessity for the effective pasteurization of this important food commodity. The first milk epidemic of which there is any record was reported from the city of Penrith in England by Taylor in 1857. Ten years later an outbreak of scarlet fever was traced by the same author to this source. Other epidemics were reported from time to time, but not a sufficient number to attract the attention of public health authorities until 1881 when Hart published his collection of milk epidemics. Since that time there have been gathered together more than 500 epidemics of typhoid fever, septic sore throat, scarlet fever and diphtheria transmitted by milk.

Kelly and Osborne made a study of 28 outbreaks occurring during 4 years in which milk was found to be the cause, or in which the evidence pointed to it as the only factor producing the disease. Of the 28 outbreaks due to milk, 16 were typhoid fever, 7 septic sore throat, only 4 of scarlet fever and one of diphtheria. It will be seen therefore that while milk as a causative factor in the spread of scarlet fever is not as significant as in typhoid fever and septic sore throat, adequate precautions must be insisted on to ensure that it does not become contaminated with the germs of this disease.

Concerning the Dick test and active immunization against scarlet fever, Zinger states that this test is a reliable index to susceptibility or of immunity to scarlet fever and in conjunction with immunization will help in solving the problem of the control of this disease, but it would appear from subsequent findings that a single negative reaction is not always to be relied upon as an indication of immunity. The doses recommended by Zinger for children under 12 years of age, namely 100, 250 and 500 S.T.D. at intervals of one week, have been found to be ineffective. In one batch of 1500 children so treated, the Dick test reapplied 2 or 3 months later, showed 50 per cent of positive reactions, indicating that no immunity had been developed. In another series of tests of 3000 cases in which 1000, 2000 and 4500 S.T.D. were used, showed 50 per cent still susceptible after a period of 6 weeks. The doses as large as 20,000 S.T.D. which amounts however, sometimes cause reactions which resemble attacks of scarlet fever. It is not known how long immunity produced by the toxin injections will last, but Park of New York as a result of his findings, has given reasons for believing that an immunity of 18 months to 2 years may be produced. There seems to be little doubt that as a result of the investigations being carried on, more gratifying improvement in the attainment of immunity will be obtained.

There is a general unanimity of opinion among those who have had large experience in the handling of epidemics of measles, whooping cough and the minor communicable diseases, that the usually prescribed measures of isolation and quarantine of contacts, exert little or no influence on their control. Outbreaks of a few cases tend invariably to assume larger and larger proportions until a high percentage of the susceptibles in the community have become immunized, but because diseases like measles and whooping cough, once having obtained a foothold, tend to run riot, does not necessarily justify an attitude of indifference on the part of the health officer, nor a neglect of their fatal consequences.

In the registration area of the United States during the 12 years from 1900 to 1911, 50,000 deaths from measles were recorded, and the measles death rate per 100,000 population in the same area varies from 4.3 to 14.3 in different years according to official statistics. Whooping cough causes more deaths than scarlet fever. In the United States registration area from 1900 to 1921 the average mortality rate was about 10.5 per 100,000 population.

Measles is almost universally looked upon as a trivial complaint, but ranks second among the communicable diseases, while whooping cough comes fourth as a cause of death, and if we could obtain a reliable census of deaths in young children, ordinarily attributed in mortality statistics to broncho pneumonia, the responsibility of these two for the fatalities occurring among the group between 1 and 5 years of age would be materially increased. Complications and sequelæ occur in one-fourth to one-fifth of all cases, so that in the registration of vital statistics the original disease frequently receives no mention. The younger the child and the younger the family the higher the death rate is likely to be. The social condition of the parents exerts an influence on both the age at which an attack may be expected and on the mortality rates, since better homes mean better care for children and the restriction of the child more to its own family or within narrower limits, so that among such families the average age for the occurrence of measles is about seven or eight, while among the working classes it is under five, below which age the majority of the complicating broncho pneumonias make their appearance. Where whooping cough or measles breaks out in a family of small children, it is here that a well trained intelligent public health nurse is able to exert her maximum of influence over these diseases and their baneful consequences, by keeping in touch with the physician or health officer when necessary, by informing the mother as to their seriousness, seeing that the child is kept in bed under hygienic conditions, and assisting with bedside care when such is required.

Among the general measures for the control of measles and whooping cough notification, obviously, comes first, since it is impossible for any attempts at control to be successful, in the absence of knowing where disease exists. Information with respect to cases or suspicious cases should be accepted from all available sources, physicians, householders, public health nurses and teachers of the elementary schools. In measles the great difficulty encountered is the onset of the disease, which is characterized by symptoms which simulate a common cold. Another superstition of the general public that has to be overcome is the wide spread opinion that every child must have the disease, and the sooner the trouble is over the better—a consoling reflection for the parents but

of very doubtful application as far as the health of the child is concerned. Isolation, quarantine of exposed susceptibles and concurrent disinfection are important as in other communicable diseases. Schools should not be closed or classes discontinued where daily observations by a doctor or a nurse can be provided for. Mothers should be warned of the danger of having younger children come in contact with those suffering from acute catarrhal conditions of any kind. The use of whole blood of convalescent patients in measles or of healthy immune adults within 5 days after exposure, will avert or modify an attack in an exposed person in a large percentage of cases and this procedure is of value in checking the spread of infection in institutional outbreaks.

It is the duty of the health officer to realize how important hospitalization and appropriate treatment there of the serious cases of measles, scarlet fever, and diphtheria has become. This is shown by the records of the Willard Parker Hospital in the management of these three diseases for the first 3 months of 1927 as contrasted with the first 3 months of 1922.

	1927			1922		
	Cases	Deaths	Mortality Per cent	Cases	Deaths	Mortality Per cent
Scarlet Fever	334	8	2.3	449	128	25.7
Diphtheria	407	33	8.1	236	35	18.8
Measles	15	2	13.3	488	114	23.3
Totals	756	43	5.6	1,223	277	22.3

In the control of whooping cough, the chief difficulty in limiting the spread of the disease is undoubtedly the missed cases of the mild type in which the disease only assumes the catarrhal stage and in which the characteristic whoop is not developed. Convalescent carriers are not considered a serious factor in its spread. It is stated that a positive diagnosis of the causative germ may be made by bacteriological examination of the discharges from the larynx one week before the development of the whoop. In addition to quarantine, isolation and concurrent disinfection, some authorities recommend the vaccine as a prophylactic against the spread of whooping cough. Miller formerly Director of the Division of Communicable Diseases, Health Department, Akron, Ohio, has expressed his conviction of its effectiveness as follows:—"Experience seems to show that sufficiently large doses of Bordet bacilli establish a positive immunity against whooping cough and check the spread of the disease in the public schools. Whooping cough vaccine is the only therapeutic measure worthy of consideration in the treatment of the disease. Failures are due entirely to insufficient, timid dosage at too long intervals. I believe that public health authorities are justified in promoting immunization against whoop-

ing cough just as they are in urging immunization against typhoid fever."

In whooping cough the communicable period does not last probably longer than 3 weeks after the characteristic whoop, so that in instituting measures for its control the communicable period must be regarded as extending from 7 days after exposure in an individual who has the disease, to 3 weeks after the appearance of the characteristic whoop.

German measles, chickenpox and mumps, are widely prevalent in cities during the winter and spring months, are not attended by mortality and do not give rise, except in the case of mumps, to complications worthy of serious attention. Both German measles and chickenpox constitute however a problem of some concern to the health officer and necessitate an amount of supervision entirely out of proportion to their real significance, by reason of the liability of German measles to be confused with morbilli on the one hand and with scarlet fever on the other, and of chickenpox to be mistaken for smallpox. Since the opening of schools in Hamilton on September 1st, 1926, there have been reported to the Department of Health about one thousand cases of chickenpox alone of school age and an additional one thousand among pre-school children. If the average number of contacts quarantined for the individual case be taken as one, with an average absence from school of ten days each for patient and contacts, the incidence of this trivial malady during the past eight months represents a loss of school attendance totalling in one city alone, 20,000 days, a huge economic loss to the community, which is equalled during visitations of German measles and mumps, and for which the time and energy consumed by the health officer and his assistants, in enforcing existing regulations with regard to their control would seem to obtain but few compensating advantages.

It is impossible to estimate the true value of the practices in vogue for dealing with such respiratory infections as influenza and pneumonia or of diseases like poliomyelitis and epidemic meningitis. In epidemic meningitis we are assisted in the recognition of the disease by the use of the microscope for examination of the spinal fluid and of the nasal and pharyngeal secretions. Carriers in this disease vary from 1 per cent in the general population, to 80 per cent of those known to have contact with disease among military units. Our ignorance of the epidemiology of the disease, the presence during outbreaks of large numbers of carriers, and the existence of mild and undetected cases make the problem of the administrative control of meningitis very difficult. The isolation of so called meningitis carriers has been barren of effective results, and we are forced in this disease to rely on general measures such as improvement in ventilation, the prevention of crowding in such places as camps and military establishments, education in personal hygiene, avoidance of bodily fatigue,

excess in eating and drinking, and the utilization of measures for the promotion of general health, The meagre knowledge which we possess of the cause and mode of transmission of infantile paralysis renders us as helpless in the presence of this disease, as in epidemics of meningitis. The epidemic of poliomyelitis in 1916 typically exemplified our inability to account for the spread of the contagion or to devise measures for its control. Contact, insect, milk, air, street dust and animals have been evoked as the medium for the carriage of the virus, but at the present time we cannot demonstrate that any one, any two, or all combined can account for the eccentricities of this disease. Until accurate information is forthcoming as to the manner in which the disease is transmitted, health authorities are justified in requiring notification, isolation, quarantine and concurrent disinfection of all materials freshly contaminated by discharges from the nose, throat or bowel of infected persons.

Notification, isolation and quarantine of infected persons in acute respiratory infections such as pneumonia and influenza would appear to be of little avail in lessening the spread of infection, but since proper treatment at the outset in bed is desirable in all cases and hospitalization of the serious cases is demanded, as an assurance to their receiving prompt and suitable treatment, it is the manifest duty of the health officer to obtain as complete a record as possible of all cases through the maintenance of a bureau of information and also through the medium of his staff of doctors, nurses and voluntary workers, to assist in seeing that all those infected may be advised as to the necessity for treatment in the initial stages and the adequate medical, nursing and hospital service is provided wherever possible. The pandemic of influenza in 1918 and 1919 fully attests the helplessness of isolation and quarantine. Every kind of restrictive measure which the ingenuity of the medical mind could conjure up, and in some instances every conceivable absurdity, was adopted and pressed ruthlessly into service with no apparent effect in retarding the march of influenza from country to country and from community to community except to emphasize their futility and our impotence in the presence of this devastating scourge. No definite plan of community protection has been worked out. We certainly have no assurance that quarantine, isolation, or restrictive measures will be more successful in the event of another pandemic than they were nine years ago, but it is conceivable that having benefitted by the experience of the past the available resources at our disposal for dealing with a situation such as arose in 1918, may be better organized, and husbanded in such a manner as to obtain a maximum of efficiency. It may be possible in dealing with certain isolated groups to lessen the number attacked, and to spread the duration of attack over a longer period, thus giving better opportunity for

individual care of those infected and as a consequence lowering mortality even though morbidity rates may be little changed.

The duty of the health officer in the control of tuberculosis has been sufficiently touched upon in the address by Dr. T. W. G. McKay, President of the Association, and as this paper is already considerably longer than it was originally intended to be, I shall omit any reference to the control of the venereal infections as belonging to another category than that of the acute communicable diseases. I would like to emphasize however before closing, that the control of communicable diseases is one of our great community problems, if not our greatest community problem, and the most important duty of the medical officer of health. In an editorial written for the American Journal of Public Health of March 1922 the following statement appears—"It is well known that . . . . less than 10 per cent (of all deaths) are due to communicable diseases", to which opinion Dr. H. W. Hill sent to the editor in the May number of the same Journal the following reply:—"This is so extraordinarily incorrect a statement, and appears so prominently in your editorial columns that I believe it only right to call attention to it.

The facts are that over ten per cent of all deaths are due to tuberculosis alone; another 10 per cent to pneumonia; a third 10 per cent (I give round numbers) to heart disease, which is chiefly a focal infection end-product. And to these three communicable diseases (infections) alone therefore are due over 30 per cent of all deaths!

Tabulations relating to this very point concerning the causes of death in 1917 (given in the 1918 Mortality Statistic records of the U.S. Census for the registration area) have just been completed by myself.

In round numbers the causes of death were communicable (infectious) diseases in 61 per cent (*not* "less than 10 per cent"!) of the total (1,066,771) deaths. The remaining 39 per cent of causes of death given include a group of indeterminate terms, ("other diseases," and such like) which could not be definitely classified as infectious or not. Eliminating these, 70 per cent of the remaining deaths (*i.e.*, 70 per cent of all those deaths the causes of which were given in recognizable terms) were due to infection. The other 30 per cent were due to such causes of death as external violence, malformation, infancy, old age, chemical poisoning. These are not in the popular mind "diseases." If we eliminate these and confine ourselves to what we usually and popularly understand as "diseases," we find that of 745,114 persons who died of "disease" in this sense the cause was an infectious disease in 88 per cent (not "less than 10 per cent"!).

Whether we except in their entirety the conclusions of Dr. Hill or not as to the percentage of deaths attributable to the communicable

diseases, are we not justified in believing, the saving of these lives and the prevention of these diseases to be one of the chief responsibilities of government, and if so, should not the health officer be supported by an organization, financial assistance, and a continuity of service sufficiently satisfactory to enable him to direct his best efforts toward the task imposed upon him?

Medical Inspection of Schools in Brantford

Report of Dr. C. C. Alexander, the School Medical Officer for the City of Brantford

I beg to present a brief summary of the work of the Medical Inspector done in the Public Schools of Brantford for the year 1926-1927.

Complete physical examinations were made of three thousand and sixty-seven children. This was 80% of the total number who received the usual permission request cards.

The Board of Education presented an appropriately worded certificate of health to every child examined. These certificates were much appreciated.

Eight hundred and thirty-eight, 36.25% of the children examined were accompanied by their parents. This was the greatest number of parents present at the examinations during any year since the commencement of the work.

The value of an annual physical examination for every person is gradually and certainly gaining recognition. The leading life insurance companies are emphasizing this and are urging their policy holders to avail themselves of a free yearly examination. There can be no doubt of the value of such an examination when the insurance companies and advanced medical men generally are united in giving this advice to the adult population. The proportionately greater value of such a yearly check over during the period of growth and adolescence must be apparent to all. The early detection and correction of even minor defects at this period in life insures better development and stronger, healthier, citizens for the future generation.

No apparent defects were discovered in approximately eighteen hundred and fifty-six of the children examined. This was a very marked increase in the number of those who are physically fit. I consider this to be a marked tribute to the value of the past seven year's repeated follow-up work in the various schools. The vast majority of those who were physically fit were in the senior grades.

The increasing interest by parents, teachers, and family physicians justifies the hope that the number of physically fit children will become greater year by year.

Three hundred and thirty-seven children had diseased tonsils and

adenoids removed during the year and over one hundred cases of visual defects were corrected.

Thirty-one children were referred to their family physician because of suspected pulmonary disease, and were re-examined in the diagnostic chest clinic. Eleven children were admitted to the preventorium or sanatorium since September 1926. These were all early cases, who invariably will recover, and who, because of this early diagnosis are prevented from becoming a source of infection in the various families and class rooms. Were there no other results obtained from the medical inspection of the schools, this detection of early cases of tuberculosis would justify the work and would pay the City of Brantford big returns on the money invested in medical inspection in the schools.

Signs of organic heart disease were discovered in fifty-two children. Adequate care will promote a cure in the majority of patients at this age.

Three hundred and sixty-five children remained ten per cent or more underweight during the year. Observations and follow-up work lead to the conclusion that this condition in many cases is due to insufficient rest and sleep. Frequently such children are too tired to get up in time to take a proper breakfast, and hence the lack of normal increase in weight in proportion to the height and age. Holt, the noted children's specialist, states "That from six to ten years of age, the average amount of sleep required is from ten to eleven hours and from ten to sixteen years, nine hours should be the minimum." Children who are inclined to be delicate, have had a severe illness or who are nervous or irritable, or backward in their classes should increase this period of rest and sleep by one or two hours daily. Those who are underweight, or not gaining normally will frequently improve if from one-half to one hour daily rest is taken lying down after the mid-day meal.

The enforcement of the law compelling children sixteen years of age and under to be off the streets by nine o'clock has been of material advantage.

Brantford schools have been particularly fortunate in escaping any thing approaching an epidemic of Scarlet-fever or Diphtheria during the past year. Health authorities, throughout the entire world, are united in urging parents to give their children the protection afforded by the inoculations to prevent those two diseases. Security and protection against Scarlet-fever and Diphtheria is within the reach of all. I trust the time is not far distant when such diseases will be as rare as Typhoid Fever is to-day in all properly organized health communities.

I wish to take this opportunity to thank the school nurses for their untiring efforts to place the advantages of modern health methods in

every child's home in this City. The teachers and all those associated with the schools have continued to encourage and aid in every possible way the work of medical inspection. Their co-operation is truly appreciated.

The Tuberculosis Hospital and Its Facilities for Teaching Public Health

By E. MacPherson Dickson
Lady Superintendent, Toronto Hospital for Consumptives and Queen Mary Hospital for Consumptive Children, Weston, Ont.

THE importance of teaching the principles of Public Health need hardly be emphasized at the present time. It has been diligently advocated for many years, and with such effectiveness that it is now recognized that it is highly desirable that ample provision should be made in every community to this end. To no group, however, is this subject of Public Health of more importance than to those who comprise the nursing profession. While in times past it may have been thought sufficient that the nurse should be familiar with the procedures necessary in the care of the sick, the progress of time and the advancement of medical science made it necessary for her to be proficient not only in this but also in the observation of symptoms and complications that may present themselves in different disease conditions. So now, when the enlarging field of Medical Science has introduced an important department known as Preventive Medicine, it is very essential that every nurse should be familiar with the more important matters pertaining to Public Health.

Much thought has been given by prominent teachers and outstanding leaders in the profession as to the best method by which this subject may be presented to the nurse. Some have advocated the development of post-graduate courses of study in this particular subject, requiring the expenditure of much time for intensive study, neither of which can be felt to come within the capabilities of the average nurse. And yet it is to all nurses, and not only to the few who may be able to specialize in this subject, that it is desirable that instruction should be given. And in this connection it would seem that much available material and numerous opportunities are being overlooked which might readily be utilized during the time the nurse is receiving her training. It is surprising how much there is on every hand from day to day by which this subject may be brought to the attention of the nurse as she lives her life in a hospital. And it is with the purpose of drawing attention to the facilities already to hand that a consideration of this subject has been suggested. The title need not be regarded as an exclusive one,

because whatever applies to a hospital or sanatorium for tuberculosis applies to an almost equal extent to a hospital of any kind.

There can be no question that the principles of Public Health can be best learned by having attention drawn to them from day to day in the actual environment in which the nurse is living. The study becomes then one of interest and a knowledge of the subject is acquired almost unconsciously as a matter of current interest and not by a conscious voluntary effort. Knowledge thus acquired is more permanent and more likely to be applied in the affairs of every-day life. For this reason as well as because the subject can be taught more advantageously than is possible in any formal course of study that the method is worthy of consideration at this time when time available for teaching nurses seems to be encroached upon by so many requirements.

The consideration of the subject, "The Tuberculosis Hospital and its Facilities for Teaching Public Health," may be approached with advantage under two headings: First, what should be taught the nurse under the title of Public Health; and, second, what material and opportunity does a hospital or sanatorium afford for the study, illustration or practice of the principles of Public Health as considered from the viewpoint of the nurse.

Health has been defined as the quality of life that renders the individual fit to live most and to serve best, while Hygiene has been defined as the Science and the Art (theory and practice) of the preservation and promotion of health and life. Then, in order to be consistent in our teaching of Public Health to student nurses, not only must we see that they are taught the principles of personal hygiene, but also that they are provided with an environment that is conducive to good health, *e.g.*, the students should be properly housed, they should be given a well-balanced diet, attractively served; they should have some time at their disposal each day for relaxation and recreation; they should not be permitted to remain on duty when complaining of ill-health, nor should they be permitted to return to duty at an earlier date than would be permitted in the case of a regular hospital patient. A complete physical examination of the student should be made annually and the conditions under which student nurses work should be as far as it is possible to make them so, compatible with the modern teaching of public health, for life is something more than a matter of digestion, circulation and nerve response.

Precept without opportunity for practice in matters of health soon robs the student nurse of any appreciation of the value of health education which she may have had before she entered the school; but, on the other hand, if, under approved conditions, nurses are instructed in the principles of hygiene for the individual, they are in a position to

appreciate the importance which is now attached to the subject of public health; then will their interest be aroused in the hygiene of habitations, of foods and food supply, of water supply, of sewage disposal, of occupation, and of childhood. They should develop for themselves a keener interest in the control and prevention of communicable disease as well as in the important matter of rehabilitation.

A brief description of one of our tuberculosis hospitals may enable you to judge as to the possibilities of such an institution for the study, illustration and practice of the principles of health considered from the viewpoint of the nurse. Imagine, if you will, a little village, with a population of 500 persons, situated in a township and lying between two small towns. In this little village may be found three rooming houses, accommodating approximately 125 persons; two private residences, a public school, including kindergarten and household arts departments with a daily average attendance of thirty students; a church, a public library, a barber shop, a dry goods shop, a grocery shop, a stationery, china and hardware shop; a shoe-shine parlour, a shoe repair shop; a photograph gallery, a postal station, a concert hall, a movie, a radio and local broadcasting station, a garage, a drug store, a greenhouse, a soap factory, a plumber and steamfitter shop, two carpenter shops, a dressmaking establishment, a household linen shop, a novelty shop, a morgue, a steam sterilizing and disinfection plant, a public health laboratory, a chest clinic, a dental clinic, an eye, ear, nose and throat clinic (the two latter being both treatment and diagnostic clinics); two office buildings, an electric light plant, an artificial ice plant, a modern central heating plant, a sewage disposal system, an interurban cartage agency, an incinerator, a steam laundry, handling over eight thousand pieces per week; a dairy produce depot, having modern refrigeration facilities and handling one thousand gallons of milk and three hundred dozens of eggs, five hundred pounds of butter, as well as fifteen hundred loaves of bread, weekly; a butcher shop handling eight hundred and twenty-five pounds of meat and fish weekly. There are also five restaurants in this village which serve an average of fifteen hundred meals daily. The recreational facilities afforded by this village, not already mentioned, consist of two tennis courts, a billiard parlour, a bowling green, a clock golf course, and a supervised play ground for children. In this village there are many subsidiary industries, such as market gardening, floriculture, poultry raising, hog raising, a livery stable, and such like, without making any mention of three hospitals affording work for four physicians, sixty nurses, a bacteriologist, a dentist, a play-ground supervisor, a director of physical education, two stenographers, a justice of the Peace, several clergymen and numerous social workers. Such a village would ordinarily be considered a place of some

importance if located at Jenkinson's Corners, especially if it were casually intimated that it had sufficient of interest to attract more than 1,000 visitors each week, and it might even be coveted by teachers of Public Health as desirable for the purpose of field work for students. Yet in spite of the fact that there are in Ontario at least four institutions similar to the one just described and at least one in each of the remaining Provinces, with the possible exception of Prince Edward Island, this excellent field work available for health study has been almost entirely overlooked, since in few of the Provinces have these fields been utilized.

A tuberculosis hospital, on account of its location, and because it is a self-contained community, presents problems of the rural community while it also affords the advantage of city life. In such an institution the students can study the average so-called normal child in respect to diet, school and play, and the daily routine of life of such a child as well as that of the sick child. She has an opportunity to study the provision that is made for the proper housing and caring of employees engaged in a variety of occupations common to a village group. She may see the provisions that are made for approved methods of handling infective material and the disposal of waste, the storing of food supplies, and the purification of water, while adjacent dwellings with their inadequate or antiquated systems of water supply and sewage disposal will serve as contrasts to approved methods.

The regulations relating to the quality, storage, and sale of food stuffs may be learned in the food storage department since food must be bought and stored in large quantities when institutions are remote from centres of distribution.

The kitchens and dining-rooms of these institutions afford splendid opportunity for impressing upon the mind of the student the laws governing the preparation, screening and serving of foods, as well as the inspection, education and supervision of all those who are engaged in the handling of food supplies; here, also, the points considered in the grading of restaurants for approved or standard certificates may be checked up by the student.

We need not take time to further enumerate the other departments which will suggest themselves as abounding in illustrative material for the teaching of public health, nor is it necessary to emphasize the fact that the reporting of communicable disease, the public measures taken toward the control and prevention of these diseases, and the governmental and municipal responsibility for maintenance of those suffering from such diseases will mean something very real to the student who has had actual contact with those being so reported and cared for.

Health Education is already one of the first responsibilities of the sanatorium to patients and their friends, as well as to its employees.

There is, therefore, in such an institution an opportunity for the student nurse not only to partake of this instruction but also to develop for herself the art of teaching health to those with whom she comes in contact.

It is not within the scope of this paper to enter into the details of the actual teaching of Public Health to student nurses, but I submit that in a tuberculosis hospital where there is an enthusiastic teacher interested in public health, acting as director of the student group, and where there is the co-operation of a permanent staff of graduate nurses and a sufficient number of ward aides, the affiliating students could be given, in a period of two months, not only a modern conception of the care and treatment of tuberculosis patients and the control and prevention of communicable disease, but also such training in matters of Public Health as would make them valuable health teachers wherever they may be located after graduation.

By the use of such facilities it would be possible to give every nurse some training and instruction in the principles and practice of Public Health, and there would in this way be laid a better foundation on which to build future post-graduate courses in Public Health Nursing for those who desire after graduation to specialize in this important field of work.

To recapitulate—there are facilities in our institutions for the teaching and practice of the principles of Public Health as it pertains to:

(1) The disposal of sewage.
(2) The collection and disposal of garbage.
(3) The proper care of food supplies.
(4) The purification of water.
(5) The inspection and supervision of restaurants and kitchens.
(6) The supervision of healthy persons engaged in a variety of occupations.
(7) The care of the sick.
(8) The prevention and control of communicable disease.
(9) Responsibility of the individual the municipality and the province in matters of health.
(10 Child Welfare pre- and post-natal.
(11) Community recreation.
(12) Housing.

and numerous other subjects that will readily suggest themselves to any who are equally familiar with Public Health and Institutional Management.

H. *v.* M.

A Medical Slander Case

A JUDGMENT just delivered by the highest court in the Province of Ontario is of great importance to medical men by way both of warning and of guidance.

The judgment was written by the Honourable Mr. Justice Riddell; but being concurred in by his four brethren on the Bench, it must be considered an authoritative statement of the existing law.

The full text, of course, appears in the official Ontario Law Reports; but we leave out all matter not germane to the purpose of this publication.

At our request, an eminent member of the Law Society has furnished Notes for the assistance of the medical profession—these follow here the Report of the case.

. . . . . .

The plaintiff, a Civil Engineer, sued the defendant, a medical man, for libel and slander—special damage is alleged but none was proved; the action was tried without a jury, at Toronto, and resulted in judgment for the plaintiff for $500 for the libel and $200 for the slanders—(1926) 59 O.L.R., 355—the defendant appeals.

The plaintiff, being in the employ of the Canadian National Railways, made a claim, in October, 1924, to the Workmen's Compensation Board, based upon iritis which he said was caused by a blow, May 2, by a cupboard door. The Board asked the C.N.R. to report on the case and to give particulars of it to the Board. The Board's medical officer wrote asking for a full report of the accident, and asking the railway if they wanted to have any examination of the claimant made, as apparently no treatment was given until some time after the alleged accident. A Claims Agent of the C.N.R. took the matter up in consequence of this request; he took the plaintiff to the defendant, who was the Medical Officer of the C.N.R. for the District, and asked the defendant to investigate the case from the medical side. With the plaintiff was a certificate from Dr. C., September 25, that he had been a patient of his for four months and "had been suffering from an injury to the right eye followed by a very severe iritis." At this point should be stated a fact which seems to have been wholly overlooked.

The proceeding in question was not an action by an employee against his master for damages wherein it would be for the financial advantage

of the master to defeat, or, if that was not possible, to minimize the employee's claim—in this case, any loss the C.N.R. would be put to, would be reimbursed by the Government—the C.N.R had no interest whatever in defeating or minimizing the plaintiffs' claim.

Nor can I find anything throughout the evidence to indicate or even to suggest that the defendant, in anything he did, had any thought other than to do his duty, that is, to find out the facts as fully and accurately as possible and report them. When the Claims Agent brought the plaintiff into the defendant he was unable to relate the iritis with the alleged cause of the accident and considered whether there might not be some other cause. Clearly this was his plain duty—being called upon to go into the matter, he needs must give it the most careful consideration and inquire into every possible cause.

He remembered that the plaintiff had consulted him some years before; he looked up his records made somewhere about the time; the card record of the previous consultations was produced at the trial.

In this record is an entry: "had g.c. infection 2 years ago" ("g.c." being the medical shorthand for "gonococcal", implying gonorrhoea, one of the venereal diseases). As to how this entry came to be made there may be doubt; the defendant says he must have had the information from the plaintiff himself, but he can speak only from his record, he has no independent recollection—the plaintiff, asked how he can account for it, says:

> A.: The only thing I can get is that when I told him that I had V.D.H., I said that the only thing I had in the army besides measles and chickenpox was V.D.H., which I got in the army; and then he asked me when I was discharged from the army and I told him two years before.
> Q.: You think he may have mistaken what you said?
> A.: I think it is quite possible.

However that may be, the defendant did treat his patient in 1920 for g.c. infection, although the plaintiff says that he understood the treatment was for a possible tuberculosis. No suggestion of tuberculosis appears in the clinical card. According to the defendant, the treatment was successful—or at least represented to him by the plaintiff as effective.

In about a week after, the plaintiff went to see the defendant again—on the first occasion that had been just an examination of the eye; this time, an examination of heart, blood, urine, etc., was made. The defendant went to see Dr. H. of the Christie Street Hospital—as the defendant says on his examination for discovery, put in at the tiral—"It was in connection with the investigation necessary that I saw Dr. H." At the trial he says:

> "I went to see Dr. H., medical director of the D.S.C.R., at Christie Street Hospital. My reason for going to see him was I wanted to get some information in regard to the rheumatism in Mr. H.'s history, because I understood that he had been invalided out of the army with valvular disease of the heart, which is most frequently caused by rheumatism; so I saw Dr. H. and intimated to him that Mr. H. had made a claim against the company for compensation, and asked if he would let me have any information he might have which would bear on the condition of iritis, with special emphasis on the matter of rhematic history.'
>
> . .

Dr. H. produced the records that he had and read out that there was one item showing that there had been V.D.G infection (V.D.G. is Venereal Disease Gonorrhoea, equivalent to g.c. infection).

> "I asked him if he would let me have a letter indicating the matter of the rheumatic history and also this V.D.G. history, and he said he would not be able to do that without permission from Ottawa, and he asked me to write to him making a request for the information."

Having this information from Dr. H., the defendant went to see Dr. C. (who had given the plaintiff the certificate) at his private office and discussed the cause of the plaintiff's condition with him. During the course of this conference, the defendant told Dr. C. that he had treated the plaintiff for gonorrhoea some years before.

The defendant, after seeing Drs. H. and C., sent his report to the Claims Agent in which, *inter alia*, he said that the plaintiff "admitted having had a g.c. two years ago before I saw him," the date of this consultation being fixed at May 5, 1920. This is one of the libels complained of; I pass it over for the time being.

Following up the suggestion of Dr. H. at the Hospital, the defendant wrote him, October 30, a letter saying, *inter alia*, "He also stated that he had had a g.c. infection about 1918. I would be glad if you would advise me as to the heart condition which necessitated his discharge, also whether the records show a history of rheumatism and g.c. infection." How this letter can be construed as anything else than a *bona fide* request for information, coupled with a statement of one doctor to another of the reason for the request, passes my comprehension. That it was not the duty of the defendant to obtain this information if he could cannot be and is not said. This letter constitutes one of the causes of action. Dr. H. wrote to Ottawa for authority to give the defendant written information; receiving he authority he wrote the defendant, November 5, a letter which said, *inter alia*, "With regard to

your letter of Oct. 30th . . . it apparently covers his history which he has given you personally pretty well. This patient is a pensioner on account of valvular disease of the heart and Hypertension, aggravated on active service. According to our records, he had rheumatism at 25 years of age, evidently the starting-point of his cardiac condition."

"His Army Medical History shows a single record on his final Medical Board of his having V.D.G., which he has already told you, and presumably he had that in the Army."

Being unable to connect the eye condition with the alleged cause as Dr. C. had, the defendant, in his letter to the Claims Agent, had recommended an examination by an independent eye-specialist, suggesting Dr. McCallum, who has a deservedly high reputation—this course is admitted to have been proper. He wrote to Dr. McCallum a full statement of the views of Dr. C. and his own resultless anti-rheumatic treatment of the plaintiff, adding: "In view of this and the fact that H. admitted having had a g.c. infection two years ago before I saw him and still had shreds in the urine, I administered anti-gonococcus vaccine." He concludes by saying: "I am at a loss to understand how an iritis which came on about June 8th could be associated with the accident of May 3rd and felt that I would like to have your opinion in the case."

I am unable to follow my learned brother's unfavourable comments on this letter—the defendant charged with the duty of ascertaining the fact and finding difficulty in accepting Dr. C.'s opinion, asks the opinion of a specialist. It is the usual and wholly proper thing in asking the opinion of a specialist to make a full disclosure of the facts, to state the opinion of every physician consulted, all symptoms noticed and conditions suspected, past or present; and generally everything which can or may assist the consultee to arrive at the actual facts. Every specialist is entitled to this information; and the defendant was not only entitled to give it but it was his duty to give it. Dr. McCallum, being consulted as to the cause of the eye condition, had an interest in knowing all the facts of the patient's condition, past or present, and would have a right to complain if left in the dark without assistance. Wise specialists do not act as it is suggested Dr. McCallum should have been left to act; if a specialist declined, or did not desire the assistance which a competent previous medical attendant could give him, he would be a fool.

The plaintiff was sent alone to see Dr. McCallum, who reported that in his opinion the iritis was not "due to the blow to which he ascribed it—the edge of the door could not have hit his eye . . . he had an abscessed tooth. . . . Either this tooth or some other infection is, in my opinion, the true cause of the iritis."

The report of the defendant was sent on to the Compensation Board, as well as the letter of Dr. C.; later on Dr. McCallum's report followed.

The Board met and rejected the claim; the plaintiff asked for reconsideration, which was granted. An appointment was made for January 8, 1925; the Board required the attendance of the defendant with his records; he attended with his record card of May 3; the case stood over to enable the plaintiff to disprove the allegation of g.c. infection, etc.; to anticipate a little, on the rehearing, May 18, the defendant's letter to Dr. H. of October 30 was produced; the Board ordered an examination of the plaintiff by Dr. Trebilcock, who thought the blow had little to do with the iritis even if the globe had been hit—the claim was again rejected, June 25, 1925.

In the meantime, the original medical record of the plaintiff at Ottawa had been examined; and it was found that the copy sent to Toronto, and in Dr. H.'s possession, contained a serious error; the copy saying that he had V.D.G. infection whereas the original said V.D.H., valvular disease of the heart.

The plaintiff sued for both libel and slander; the defendant did not justify but set up Qualified Privilege as in C. *v.* D., 56 O. L. R., 209. (See PUBLIC HEALTH JOURNAL of December, 1924, p 566.)

The trial judge gave damages in Libel to the amount of $700 for the letters to Drs. H. and McCallum; and in Slander to the amount of $200 for what was said orally to Drs. H and C.

That words which impute that the plaintiff is suffering a contagious or infectious disease are actionable *per se* (that is, without proof of damage) is clear law. As is said in 7 Bac. Abr., 266:

> Man being formed for society, and standing in almost need of the advice, comfort and assistance of his fellow-creatures, it is highly reasonable that any words which import the charges of having a contagious distemper, should be in themselves actionable; because all prudent persons will avoid the company of a person having such distemper.
>
> It makes no difference, whether the distemper be owing to the visitation of God, or to the indiscretion of the party therewith afflicted; for, in every one of the cases, the being avoided, from whence the damages arises is the consequence.

And among these diseases are counted the venereal diseases. The law grew up when as yet the distinction, radical as it is, between the two commonest of them was wholly unknown, and all venereal disease was considered a form of pox, great pox, Morbus Gallicus. Consequently we must apply the older cases in which these words, or any of their many equivalents were employed, to cases involving the milder disease, and words conveying the imputation of suffering from gonorrhoea are actionable *per se*.

The rule as to imputation of past disease, generally, is correctly stated by my learned brother, 59 O.L.R., at p. 358—*i.e.*, that the words must distinctly impute that the person referred to has the disease at the time of publication of the words complained of.

It was at one period of the law supposed that it was actionable *per se* even when the imputation was that the plaintiff had had the disease. This was made to rest on Austin *v.* White, Cro. Eliz., 214 and Levet's case, do 289.

If, indeed, the question of morals entered into the matter, it might well be that, in view of the notorious fact that while these diseases may be acquired innocently, the usual cause is impure sexual intercourse, the imputation of a past infection of this character would be of graver legal consequences than that of an infection of another kind, *e.g.*, scarlet fever.

But this conception of the law has long ago received its death blow, and it is now well established that an imputation of past infection is not actionable *per se.*

The idea that it was in view of an indication of the moral character of the plaintiff that the words imputing venereal disease were actionable *per se* even if spoken of a past infection may now be ignored.

The leading case is Carslake *v.* Mapledram (1788) 2 T.R., 473.

In that case Ashurst, J., said:

> "Charging another with having had a contagious disorder is not actionable; for unless the words spoken impute a continuance of the disorder at the time of speaking them, the gist of the action fails; for such a charge cannot produce the effect which makes it the subject of an action, namely, his being avoided by society. Therefore, unless some special damage be alleged in consequence of that kind of charge, the words are not actionable."

In the same case, Butler, J., said, p 475:

> There is no distinction between a charge of this sort and a charge of the leprosy, which is to be found in the old books. In those cases it is said that a charge of having *had* such a disorder is no imputation on another, since it does not subject him to any of the inconveniences attending the having of such a disease; so of all other diseases which are contagious. The reason why the making of such a charge is actionable, is because the having a contagious disorder renders the person an improper member of society; but there is no reason why the company of a person who has *had* a contagious disorder should be avoided."

There is no foundation in law or common sense for the proposition that the effects of a disease should be considered as the disease itself,

and that the imputation that the effects of a disease exist is equivalent to an imputation that the disease itself remains. No one, for example, would consider a doctor's assertion that the deafness of a man was due to scarlet fever equivalent to saying that he still had scarlet fever at the time of speaking—or that it was equivalent to saying that one has measles, to say that his paralysis, arthiritis or tuberculosis was caused by measles. In all cases, the question is what the "words, taken with the relevant surrounding circumstances and fairly construed, mean," per Farwell, L. J., in Jones *v.* Hulton & Co. (1908) 2 K.B., 444; and I agree that the cogency of language lies in the ear of him that hears it, never in the tongue of him that makes it. "What meaning did the words convey to those who heard them?" is always the question. Capital and Counties Bank *v.* Henty (1882), 7 A.C. 741; C. *v.* D. (1924), 56 O.L.R., 209, and cases cited. And the words as spoken may convey an impression quite different from that which naturally follows from a perusal of them in cold type—accent, emphasis, intonation, gesture, all may have an influence in determining the meaning. "Don't put him in the horse trough" is not always an appeal to have regard for the safety and comfort of the agitator; and "You are a nice fellow" does not always imply a compliment to the adressee's qualities, moral or social.

There are cases in which the words "he had the pox" are actionable *per se;* but that is when the circumstances are such that the innuendoes importing that they meant an imputation that the plaintiff suffered from the disease at the time of publication, were proved.

I have read more than once everything in the evidence which could be supposed to throw light upon this enquiry and find nothing to indicate or even to suggest that the defendant's words were understood or could have been understood as imputing existing infection.

This is sufficient to dispose of the case so far as slander is concerned.

A complete answer is also afforded by qualified privilege to be considered later.

As to the Libels alleged, written defamation does not require special damage to support an action, for "the law presumes that some damage will flow in the ordinary course of things from the mere invasion of his absolute right to reputation," per Bowen, L. J., in Ratcliffe *v.* Evans (1892), 2 Q.B., at p. 528.

Moreover the falsity of the imputation is presumed in favour of the plaintiff. Belt *v.* Lawes (1882), 51 L.J.Q.B., at p. 361.

Prima facie then, the plaintiff is entitled to a verdict.

As has been said, the defendant, while he does not assert the truth of the statements complained of, claims Privilege.

"There are certain occasions on which a man is entitled to state

what he believes to be the truth about another in which policy requires that he should be protected in so doing, provided he makes the statement honestly and not for any indirect motive. Such occasions are called occasions of Qualified Privilege. . . ."

One of these occasions is when the statements complained of are "made by the defendant on a subject matter in which both the defendant and the person to whom the statements were made have a legitimate common interest": Stuart *v.* Bell (1891), 2 Q.B., at pp. 191, 3, 5.

It is not, of course, sufficient that the defendant honestly and even reasonably "believed that the person to whom he made the communication had an interest in the subject matter thereof"—that common interest must exist in fact. Hebditch *v* MacIlwaine (1894), 2 Q.B 54.

Take the letter to Dr. McCallum—the defendant charged with the duty of determining, if he can, the actual cause of the iritis of the plaintiff, is faced with the opinion of a reputable practitioner, Dr C., with which he finds it difficult to agree. Doctors, of course, differ, for Medicine is not yet an exact science. He does what any sensible and prudent doctor would do—asks the opinion of the best man he knows of on the particular disease. Dr. McCallum, being so consulted, has the right to and should be furnished the facts of the case, past as well as present, the opinions of other medical men, etc., and everything that will assist in a correct diagnosis; the defendant supplies this fairly and fully—he tells Dr. McCallum of his difficulty and asks his opinion of the case. To suggest that this was an attempt to poison the mind of Dr. McCallum is to me a patent absurdity—and the finding that they "were made solely to advance the interests of his employers, in effect his own self-interests" besides having no justification in the evidence is based upon a complete misunderstanding of what the transaction was. The defendant was not a detective employed to destroy the plaintiff's case—neither he nor his employers had any interest to do so—he was not an expert witness employed to give evidence against the plaintiff; he did not go to Dr. McCallum to prime him as an expert witness against the plaintiff—the whole evidence, including the letter complained of, shows that he wanted a better opinion than his own as to what the facts actually were, which he had been charged to investigate.

In the case of Dr. H., there is not quite the same mutuality of interest. Dr H. was not being consulted as to the cause of the existing physical condition of the plaintiff. Dr. H. was in charge of Christie Street Hospital Soldiers' Civil Re-establishment and had charge of the copies of the Medical Records of discharged men including that of the plaintiff; the defendant had been told by the plaintiff that he had been in the Army, and had been invalided out—being troubled as to the cause of the plaintiff's disability, he thought, and reasonably thought, that he

would or might be helped by the Medical Record of the plaintiff and he went to Dr. H. to see this if possible—"he wished to get some information concerning any army ill-health," as Dr. H. says. As one doctor speaking to another about such a case would naturally do, he told Dr. H. of his former patient's previous condition, and it turned out that his statement as to g.c. infection tallied with the copy of the Medical Record which Dr. H. had, which he read from, but which he did not show to the plaintiff. Anyone on such information as was read from the Medical Record would be wholly justified in complete belief in the existence of g.c. infection in the plaintiff in or about 1918. He naturally and properly desired to have something more certain than a mere verbal statement of Dr. H.; he was told that to get this required a written application; and he made written application accordingly. It said, *inter alia:*

> "Mr. H. has made a claim against this Company for partial loss of sight in his right eye following an attack of iritis, which he claims has resulted from an injury which he sustained while on duty in the Company's employ. I find it difficult to associate the iritis with the accident, but Halls tells me that he was discharged from the Army on account of valvular disease of the heart resulting from rheumatism earlier in life. He also stated that he had had a g.c. infection about 1918. I would be glad if you would advise me as to the heart condition which necessitated his discharge, also whether his records show a history of rheumatism and g.c. infection.
>
> Thanking you in anticipation of your kind assistance in this matter."

It is not contended that the defendant had not a perfect right to ask for the information he did—but it is contended that he should not have said, "he also stated that he had had a g.c. infection about 1918." It is not said, much less proved, that this statement did the plaintiff any harm directly or indirectly, but no doubt the plaintiff has the right to complain, and the defendant must meet the complaint.

While it was most natural that the two doctors should discuss the case in all its bearing, and also that the defendant, full of his subject and bearing in mind the preceding conversation, should in the letter repeat what had been said: it cannot, I think, be held that it was necessary for him to make the statement complained of in order to get the information he desired. And if absolute necessity or anything like it be the test of Privilege he must fail.

But the occasion was privileged—the letter was written by the

defendant in the discharge of a duty—and as my brother Orde points out in Knapp *v.* McLeod (1926), 58 O.L.R., p. 610:

> "The fact that a statement otherwise within the privilege may be in some respect excessive does not necessraily exclude the excessive matter from the privilege if irrelevant to the main statement. The excess is then only material upon the question of malice. . . . Nevill *v.* Fine Arts, etc. (1895), 2 Q.B., 156; . . . Adams *v.* Ward (1917), A.C. 309, at pp. 326-328."

It may be that in giving his reasons for asking for the information which, of course, he had the right, perhaps the necessity to do, the defendant, in stating what he did as to the g.c. infection, was guilty of excess in the first of the forms mentioned by my brother Orde on p. 611. This I think it unnecessary to pass upon—as I have pointed out in C.v.D (1924), 56 O.L.R., at p. 213, the tendency of the English cases is rather to extend them to restrict the privilege; and the last case in this Divisional Court, Knapp *v.* McLeod, cannot be said to be restrictive. Assuming that there was an excess on this privileged occasion, there is absolutely nothing in it to suggest malice or anything but a simple and natural mistake.

The case as to libel seems to me to depend on Malice.

Of course, all qualified privilege is removed if the defendant did not believe in the truth of what he said. That cannot be contended in the present case.

Nor can I find anything to indicate that the defendant was actuated by anything but a sincere desire to do his full duty. Personal actual malice against the plaintiff there is no trace of.

I can find no malice of any kind in the present case; and am of opinion that the appeal should be allowed and the action dismissed with costs throughout.

It is a satisfaction to know that the law in this case is in accord with common sense as it generally is when not bedevilled by the mediaeval subtlety of the ancient sages or by modern legislation.

Notes

1. Defamation is anything, oral or otherwise, which tends to bring anyone into public hatred, contempt, disregard or ridicule, or cause him to be shunned. If this be oral, it is called Slander; if otherwise, as written, printed, painted, drawn, etc., so as to be of a permanent or *quasi*-permanent character, it is called Libel.

2. Libel is actionable *per se*, *i.e.*, without actual damage; Slander, as a rule, is not. But an oral charge of being guilty of a crime or of having a contagious disease is actionable *per se*.

3. To be actionable *per se*, a charge of having a contagious disease must be of the present condition not of the past; but words which apply in their literal sense to the past, may sometimes be taken as applying to the present—sometimes, indeed, they are meant to be so taken.

4. The truth of a charge is always a defence in an action of slander; but unless it can be certainly established, it may be dangerous to plead it because, if it fails, it may be urged as proof of malice and so increase the damages. In cases such as this, Qualified Privilege is generally relied on.

5. Speaking generally, if one is under a duty to make any statement, and he does make it believing it to be true and without actual malice, the law protects him even if he cannot prove the truth of his statement. This is called Qualified Privilege as distinguished from the Absolute Privilege of Witness or Judge.

6. This Qualified Privilege may be destroyed by malice, and malice may be inferred from saying what is unnecessary.

7. Medical men have no privileges or advantages over others in respect of defamation; they are subject to the same rules and restrictions as all other classes.

8. Care should be taken not unnecessarily to say of any one that he is or has been infected venereally. A charge of present infection is actionable *per se* and a charge of past infection is not unlikely, however carefully made, to be construed as also relating to the present. Of course, every Court, Board, etc., is entitled to the fullest disclosure and a witness has absolute protection.

9. In a consultation to determine the actual condition of a particular patient, all consultants are entitled to give and to receive the fullest information concerning the patient.

10. In speaking to others, care should be taken not to say more than is reasonably necessary. *E.g.*, had the defendant's good faith not been manifest, it might have gone hard with him for his wholly unnecessary statement concerning the past venereal infection of the plaintiff in his letter to Dr. H. at the Christie Street Hospital. Of course, if Dr. H. had required this information in order to enable him to furnish the needed report to the defendant, the statement would be privileged.

The Sanitary Inspectors' Association of Canada

THE IMPORTANCE OF PROPER TRAINING FOR SANITARY INSPECTORS

Presidential Address to the Fourteenth Annual Convention of The Sanitary Inspectors Association of Canada, held at Toronto, Ontario, September 14th, 15th, and 16th, 1927.

ERNEST W. J. HAGUE,
Chief Health Inspector, City of Winnipeg.

I MAKE no apology for addressing you again on this subject, for it appears to me that so far as this Association is concerned, it is the most important topic one could select. This Association, since its foundation, has done a good deal to improve the status of the Sanitary Inspector, first by affording opportunities for the members to increase their knowledge and usefulness, and secondly by helping to remove that notion, once so prevalent—and to be found even yet amongst those who know no better—that any uneducated Tom, Dick or Harry was good enough for a Sanitary Inspector.

At the same time, in so far as Canada is concerned, we have yet a long way to travel before the inspector comes into his own. We have to convince firstly quite a large number of the sanitary inspectors themselves that in these days when Public Health Work is progressing by leaps and bounds, and when new discoveries in the conquest of disease are being made almost every year, that a person taking up Public Health Work in any of its branches cannot be content with mere routine work, but that he or she must be of a studious nature, prepared to keep abreast of this rapid progress, to know about the new discoveries, and to be prepared to apply them in his daily work. We also need to convince quite a number of inspectors yet of the advantage of belonging to an Association such as this, which exists for the benefit of sanitary inspectors and other health workers. The next class we want to convince is Health Officers. We wish to show them how much better work they will be able to accomplish when all public health workers are properly educated and trained. We also need to convince Governmental and Municipal Authorities who employ sanitary inspectors and other health workers, that they can get better value for their money by insisting on proper qualifications for such workers; and lastly, we need to convince the general public with whom we

come in contact so much, that the sanitary inspector is not a raw man pitchforked into a public position by means of some "pull", but a man specially educated and trained for his particular work.

What is a Sanitary Inspector, and what are his duties? In the first place we note a great diversity in these duties. Mr. H. P. Boulnois, late Engineering Inspector of the Local Government Board, England, once had this to say on the matter:—

"In order to carry out the multifarious duties of his office, an inspector should be partially educated in the following trades and professions, *viz*:—That of a *Plumber,* in order to detect bad work, and to be able to fill in his notices how the bad work is to be rectified. That of a *Builder,* in order to detect improper sanitary construction, and state how it must be remedied. This is of greater importance where, as in some towns, the Sanitary Inspector has to carry out the duties of a Building Inspector, and watch the erection of new houses which are being erected under the by-laws regulating new buildings. That of a *Butcher,* in order to detect and intercept bad meat. That of a *Veterinary Surgeon,* in order to observe animals that may be suffering under the Contagious Diseases (Animals) Act, and also in connection with his visits to Slaughter-houses. That of a *Lawyer,* in order that he may be well cognisant with all the Acts and Regulations under which he carries out his duties, and to enable him to form a judicial opinion upon all statements and facts. That of an *Architect,* in order that he may understand plans, and if necessary, make sketches of anything that comes under his notice in connection with his duties. That of a *Clergyman,* in order that he may preach the good tidings of sanitation, and may by his precept and example further the good work he is engaged upon, and also that he may be able to patiently bear the abuse which he may sometimes receive for what is called his 'prying interference'. Lastly, he must try and educate himself in *Common Sense,* that most valuable commodity, without which book learning availeth not much."

A few extracts from Taylor's "Sanitary Inspector's Handbook" may not be out of place here.

"To carry out his duties efficiently, the Sanitary Inspector must exercise great forbearance, tact and good temper; sometimes technical objections will be raised to his proceedings, vexatious delay and evasions will often occur in the fulfilment of his notices, nuisances which the officer is anxious to suppress may elude his authority; when he would force one person to refrain from tainting the atmosphere with the result of an offensive trade,—where he would oblige another to see that his tenants were better housed than cattle, he will often be reminded of the rights of property and of an Englishman's inviolable claim to do as he will with his own. With private affairs he should interfere only when they become of

public import, and with private liberty only when it becomes a public encroachment.

Thus neither the personality nor the office should be magnified. To do this is to court the contempt of ordinary men and women. Officialdom is the curse of any administrative body. Therefore the man who goes about his duties in a way that compels respect, and whose tactful demeanour impresses others that the thing he is asking for cannot be denied, is the one who will win his way to the front. Owners and occupiers are but human, and they like to feel that they are receiving the attention of a friend, although an official." And again speaking of qualifications—"Sanitary Authorities do not and have not always sought to appoint the person best fitted for the post of Inspector. They have too frequently appointed the man who could command the greatest influence with its members without the slightest regard to his qualifications. The important duties which Sanitary Inspectors are now called upon to discharge, and the large discretionary power that must be vested in them, demands that only qualified persons should receive these appointments, and experience has undoubtedly rendered it necessary to establish some mode of testing the competency and qualifications of persons offering themselves as candidates to fill appointments. Some assurance should be given the public that the persons entrusted with these responsible duties are properly qualified."

The modern practice in large cities is to divide a Health Department into various Bureaus or Divisions, as for instance:—

Communicable Diseases.
Sanitation and Housing.
Food Inspection.
Dairy Inspection.
Child Welfare.
Scavenging.
Laboratory.
Vital Statistics.
Publicity, etc.

The tendency in cities where the work is thus divided is for the workers in each division to develop as specialists along certain lines. In rural districts however, and in smaller places where the work is not so highly specialized, the sanitary inspector is required to do work along many of the lines indicated above. It is both desirable and necessary for all inspectors, no matter what particular line is their specialty, to have a knowledge of all branches of health work, for they may find themselves in a position where such knowledge will be essential. The Examining Boards recognize this, and their syllabuses provide for the study of a great many subjects, and the questions set at the examinations cover the

whole field of health work. This is as it should be. Workers in a narrow groove are apt to have narrow views, whereas a modern health department is a highly complex organization working along various lines, but with definite objects in view, *viz*: the conquest of disease, the prevention of sickness, the improvement of the happiness and efficiency of the human race, and the lengthening of the span of human life. It makes for the efficiency of any health department therefore, when all the workers therein have a clear view of the main objectives, and each knows something of the work being done in other divisions than his own. This means that every officer must find time to read and thus keep himself well informed as to the rapid developments in theory and practice. A doctor who did not study and read the literature pertaining to his profession, would soon become a back number.

Consider a few of the subjects which are specified in our examination syllabus:—

Water—Its source and methods of purification.
Building Construction.
Plumbing and Drainage.
Housing, both good and bad.
Sewage treatment and disposal.
Lighting.
Ventilation.
What constitutes a nuisance and how it abate it.
Offensive Trades.
Industrial Hygiene.
Milk.
Foods.
Communicable diseases: Their sources, modes of transmission, methods of prevention. Disinfection.
Child Welfare Work.
Vital Statistics.
Sanitary Law.

We must know something of all these subjects, and the more, the better. We should have a good knowldege of sanitary law, and what is more important, the scientific data on which our health laws are based, in order to be able, should occasion require it, to demonstrate to the public the reasonableness of any law which we are asking them to comply with.

In England or Scotland it has not been possible since 1877 to obtain an appointment as a Sanitary Inspector unless properly trained and certificated.

For Food Inspectors, Smoke Inspectors, Health Visitors and School Nurses, Maternity and Child Welfare Nurses, additional certificates are required. The leading Examining bodies have been The Royal Sanitary Institute, The Sanitary Inspectors' Association and The Incorporated Sanitary Association of Scotland. Quite recently the Royal Sanitary Institute and the Sanitary Inspectors' Association ceased to hold Examinations for Sanitary Inspectors' certificates, and with the approval of the Ministry of Health a new Examining body was set up entitled "The Royal Sanitary Institute Inspectors' Examinations Joint Board." The Board consists of 30 members; 15 being nominated by the Ministry of Health, 10 by the Royal Sanitary Institute, 3 by the Society of Medical Officers of Health, and 2 by the Sanitary Inspectors' Association. The offices are at the Institute and the examinations will be conducted by the Institute. The Certificate issued by the new board is now the officially recognized qualification in England and Wales for Sanitary Inspectors. In the Dominions the branches of the Royal Sanitary Institute will continue to hold examinations and to issue Sanitary Inspectors' certificates.

In Canada there are Examining Boards in Quebec (1901), Ontario (1914), Manitoba (1913), Saskatchewan (1916), Alberta (1917), British Columbia (1920). Some of these Boards, however, do not present much appearance of activity. Manitoba seems about the only Province where examinations have been held recently. This, however, is no doubt largely due to the fact that during and since the War, all Municipalities have been exercising great economy, and appointments of new inspectors have been few. However, we are over the bad times now and must be prepared for expansion. If the Examining Board in your Province is not functioning, find out why. Only recently a candidate from Regina had to come to Winnipeg for examination.

The Royal Sanitary Institute is willing to co-operate with the governments of the various Provinces of Canada by erecting new examination Boards with representatives appointed by these governments on the Boards, and that the name of the government shall appear on all certificates granted. I know that this offer has been made in Manitoba. It should be noted that the certificate of the Joint Examination Board in England will be harder to get than the old ones, mainly because a much higher standard of preliminary education is required of the candidates. Some secondary education is also insisted upon. Candidates in addition to this must have attended a six months course of lectures and demonstrations at an Institute recognized by the Board, and also received practical training in a Public Health Department for at least 300 working hours during a period of one year. The Ministry of Health is making arrangements with Municipalities for the giving of this training.

This is a very brief description of the new regulations but it indicates a movement towards a much higher standard for sanitary inspectors in England and Wales. New Zealand and Australia are moving in the same direction. What about Canada? Outside of the Province of Saskatchewan and the City of Winnipeg, I know of no place where the obtaining of a certificate is required as a precedent to appointment. Surely now that Canada ranks as a nation we should not be satisfied with anything but the best. One of the main objects of our Association is to promote the knowledge of sanitary science. How can we do this if we ourselves have not that knowledge? One of the difficulties in this new country has been the lack of courses of lectures for sanitary inspectors, and of opportunity for gaining practical knowledge. The Universities should provide the necessary classes. Practical training might be obtained by students in acting as voluntary part-time helpers in Health Departments. All, however, might not be able to get to the University centres, but in the larger cities private classes under a good tutor can accomplish much. This method has been very successful in Winnipeg. But even isolated students should not despair, for many students have prepared themselves for examination by private study. A course of lectures or a class held for students studying for examination, should be quite different from a short course of lectures intended for inspectors holding official positions. In the first instance the student has to begin with the elements of the sciences, such as arithmetic, mensuration, geometry, physics, chemistry, etc., before commencing to consider the application of these to sanitation. The period of study must cover a fairly long interval. The short courses on the other hand are intended for practical men already knowing a good deal about the subjects dealt with, but anxious to acquire the latest and best information. Examples of the latter may be found in the Lectures and Demonstrations provided in England by the Royal Sanitary Institute, or by the courses in Dairy Inspection now being given in England as arranged for by the Ministry of Health.

This Association stands for the enactment of legislation in all the Provinces which will require, in the case of future appointments to the position of sanitary inspector, a qualifying certificate from some recognized National Examining Body.

We do not advocate this because we believe that a man who has succeeded in obtaining a diploma knows all about public health work. It takes years of practical experience to become really well qualified; but we claim that men and women who have taken the trouble to obtain a certificate are likely to more quickly become valuable workers. Some Health Officers say that they prefer to train their own men, and no doubt a few Health Officers do good work along this line. Most of them,

however, are too busy to attempt to do this. If I were a Health Officer and had to break in new men and train them to be useful, I should at least like them to know something of the sciences underlying the work, something of the triumphs of public health work in the past, and an idea of the best methods now pursued in this and other countries. I am rather amazed at the indifference of many Health Officers as to the qualifications of the men who are given them to work with. One would think, in view of the fact that considerable importance is to-day attached to the proper training of Health Officers, Bacteriologists, Public Health Nurses, and other health workers, that both the Canadian and American Public Health Associations would have, before now, adopted some scheme to help the sanitary inspector also.

It should be clearly understood that what has been said about certificates being compulsory does not apply to sanitary inspectors already holding positions. By dint of study and hard practical experience many of these are the equal of any certificated men. We need them all within the fold of our Association.

We want to raise the status of the whole profession, and the best, and in fact the only way to do this, is by means of education. We claim to be technical experts and that we should receive remuneration on the scale of technical experts. This can only be accomplished first, by actually becoming technical experts, and next by convincing Health Officers and employing authorities that we are entitled to better consideration as such. Get the technical ability and the remuneration will follow naturally. This education should be continuous. Systematic reading on subjects pertaining to public health work is an absolute necessity. There are available a large number of text books, reports and Journals. We should have a conception of what is being done all over the world in public health work.

I said at the beginning that our first task was to convince the sanitary inspector himself of the importance of education and proper training, and of a continuous process throughout life absorbing knowledge pertaining to his chosen profession and trust that what I have said may convince some of this necessity.

The next most important work of our Association is to convince Health Officers of this necessity for trained men. Sanitary Inspectors have not the slightest desire to usurp in any way the functions or prerogatives of Health Officers. On the contrary, our sole desire is to make ourselves as efficient as possible so as to become what we should be, *viz*: the right hand of the Health Officer. In England the position of a Sanitary Inspector is different. There he is a Statutory Officer and may exercise certain powers, independently of the Health Officer. In Canada,

however, the Health Officer is in supreme control, and personally I think our's is the better system, and tends to better work being done. What could a Health Officer accomplish without his assistants. Imagine a well qualified man—a D.P.H., if you like—being appointed as Health Officer of a large City and given no assistants. He would naturally say "What do they expect me to do? Where are my Sanitary Inspectors, my Food and Dairy Inspectors, my Communicable Disease Inspectors and nurses, my Bacteriologist? I want these and I want good men and women, properly trained, if you expect me to do anything of value for the community."

And so we appeal to the Health Officers present, as well as those absent, for a more active support. We suggest that Health Officers might help along the following lines:—

1. Demand that the public health workers appointed to assist them shall be properly qualified.
2. Assist in procuring such legislation in each Province of Canada as will prevent the appointment in future of unqualified persons.
3. Assist in the training of the men and women composing their staffs, both by their own personal instruction, and by helping to secure the provision of lecture courses and demonstrations for Sanitary Inspectors.
4. In Provinces where the Royal Sanitary Institute has at present no Examining Boards, to assist in having such Boards appointed. If a Canadian Certificate is desired, arrange with the Government of each Province for a Joint Examination Board composed of representatives appointed by the Government, the Royal Sanitary Institute, and the Sanitary Inspectors' Association. In each Province the Examinations might be almost uniform and the Certificate issued to successful candidates might bear the name of the Government of that Province. This certificate should, however, be recognized throughout Canada as the officially recognized certificate required as a precedent to appointments, and should be required by law for all future appointments after a given date. It might even be possible to arrange with the Dominion Government and the Royal Sanitary Institute for the establishment of an Examination Board for all Canada. Such a Board comprise five or more members for each Province.
5. Give this Association and the Branches thereof their personal sympathy and support.

If we can induce Health Officers to do this, good results will follow. If our Chiefs, the Health Officers of Canada, see that we are in earnest

in this matter, they can scarcely refuse to help in a matter which so closely touches them and their work.

The above remarks apply equally to Mayors, Aldermen, and those responsible for appointments to positions in health departments. This Association is not a Trades Union, and does not exist for the purpose of raising salaries. But, if you are going to appoint men and women to help to carry on this great work, why not make sure that they know their job. If well qualified, they will be cheaper in the end.

The Sanitary Inspector and the Public Health Nurse come into daily contact with more citizens than any other health officials. In the course of their daily work they are called upon to discuss health topics and measures. They should be well qualified to do this convincingly, and also be able to correct some of the inaccurate notions found amongst the public and obtain their co-operation.

Just a word here lest anything I have said should convey the impression that there are no certificated inspectors in Canada. There are many, and most of them belong to our Association. Six candidates obtained certificates in Manitoba in April this year. If certificates become obligatory there will be no lack of applicants.

In conclusion I would like to express our appreciation of the kind assistance already given to our Association and its members by many Health Officers in various parts of Canada, some of whom we are proud to have as Honorary Members, and also by other men prominent in public life who are intensely interested in making our Canada the healthiest country in the world.

The Sanitary Inspectors' Association of Canada

PROGRAMME OF THE FOURTEENTH ANNUAL CONVENTION HELD IN TORONTO, ONTARIO, SEPT. 14th, 15th and 16th, 1927

Wednesday, September 14th

9.30 a.m. Registration of delegates, Room 22, City Hall.
Addresses of Welcome by His Worship Mayor Foster, Hon. Dr. Forbes Godfrey, Minister of Health for the Province of Ontario, and C. J. Hastings, Esq., M.D., Medical Officer of Health, Toronto, Ontario.
Presidential Address on "The Importance of Proper Training of Sanitary Inspectors", by Mr. E. W. J. Hague, A.R.San.I., Chief Health Inspector, Winnipeg, Manitoba.
Paper on "Domestic Sanitation", by Mr. H. Cusack, Chief of Division of Sanitation, Toronto, Ontario.

12 noon. Adjourn for lunch.

2.00 p.m. Drive around the City.

7.30 p.m. Paper on "The Duties of a Sanitary Inspector as related to those of the Medical Officer of Health", by Dr. D. V. Currey, M.O.H., St. Catharines, Ontario.
Round table discussion on "Our Association, its past, present and future", by Mr. A. Officer, Secretary.

Thursday, September 15th

9.30 a.m. Visits of Inspection to the City Sewage Disposal Plant, and Garbage Destructor.

2.00 p.m. Paper on "Industrial Health and its Relation to the Community", by J. G. Cunningham, M.D., D.P.H., Director, Division of Industrial Hygiene, Ontario.
Paper on "The Progress of Household Sewage Disposal", by Mr. A. E. Earl, Plumbing Inspector, Toronto.
Paper on "Milk-borne Typhoid and the part played by the Sanitary Inspector in its prevention", by Mr. W. C. Millar, Provincial Sanitary Inspector, Ontario.

7.30 p.m. Annual Business Meeting.

Friday, September 16th

9.30 a.m. Unfinished business.
Paper on "Food and Public Health", by Mr. A. R. B. Richmond, V.S., B.Sc., Director of Food Control, Toronto.
Paper on "The proper methods respecting chlorination of water supplies", with a demonstration by Mr. J. Van Benschoten, Manager, Wallace & Tiernan, Limited, Toronto.
12 noon. Adjourn for lunch.
2.00 p.m. Trip to the Island filtration plant.

ONTARIO

The Provincial Department of Health of Ontario

Communicable Diseases Reported for the Province by Local Boards of Health for the Weeks Ending August 6-13-20-27, 1927.

COMPARATIVE TABLE

Diseases	1927 Cases	1927 Deaths	1926 Cases	1926 Deaths
Cerebro Spinal Meningitis	—	5	6	2
Chancroid	3	—	1	—
Chicken Pox	169	—	136	—
Diphtheria	175	9	158	13
Dysentry	1	1	—	—
Encephalitis	—	1	—	—
Gonorrhoea	128	—	107	—
German Measles	21	—	24	—
Measles	205	—	320	—
Influenza	2	1	—	—
Mumps	52	—	2	—
Pneumonia	7	75	—	67
Poliomyelitis	3	—	5	—
Scarlet Fever	123	1	106	—
Smallpox	69	—	17	—
Syphilis	90	—	48	—
Tetanus	1	—	—	—
Erysipelas	3	—	—	—
Tuberculosis	92	42	95	59
Typhoid	141	2	43	2
Whooping Cough	297	3	256	8
Endocarditis	—	1	—	—
Septic Sore Throat	2	—	—	—

The following Municipalities reported cases of Smallpox:—

Ottawa 38, Belleville 3, Sarnia 1, Smith's Falls 8, Ayr 5, Waterloo Tp. 4, Guelph 2, Hamilton 2, York East 6.

Health Exhibit in Toronto

Commencing on Monday, September twenty-sixth, the Canadian Social Hygiene Council in co-operation with many other organizations has carried on a Health Exhibit of a somewhat new type at its headquarters at Hygeia House, Toronto.

Co-operating organizations include the Federal, Provincial and Toronto Departments of Health and National organizations such as the Canadian Tuberculosis Association, the Canadian National Committee for Mental Hygiene, the Canadian Child Welfare Council, the St. John Ambulance Association, the Canadian Red Cross Society, the Victorian Order of Nurses, the Boy Scouts Association, the Canadian Life Officers Association, the Metropolitan Life Insurance Company; in addition, the safety organizations and many Toronto organizations who are in one way or another connected with the work of the Council.

The exhibit is a first attempt to cover the broad field of Social Hygiene recognizing the inter-relation of many factors which make for unnecessary illness, premature death and social disability in a community. It commences with a booth devoted to pre-natal care. This is followed by another booth covering the care of infants. Then in succession there are booths devoted to the pre-school child, the school child, the adolescent, the young adult and the adult.

One of the main ideas of the exhibit is to stress the idea of periodic health examination. This idea is prominent in the adult section and statistics and posters provided by the Canadian Life Officers Association and the Metropolitan Life Insurance Company in particular are much in evidence.

Moving-pictures and addresses on various phases of health are in evidence twice daily, and as the JOURNAL goes to press the crowds of Toronto citizens attending the exhibit have been increasing daily.

The Venereal Disease question is covered by a separate exhibit which is to be shown alternately to audiences of men and women, with special speakers.

The Health and Hygiene Exhibit, as it is called, is apparently the first of its kind to be shown in Canada, and it is hoped that after the showing in Toronto efforts will be made to take it to other Canadian cities.

Editorial

AUTOMOBILE ACCIDENT PREVENTION

A recent statement by the Metropolitan Life Insurance Company in connection with deaths resulting from automobile accidents provides one with considerable food for thought in connection with the varying phases of life conservation.

It is stated that in the year 1924 and 1925 no less than 2,833 industrial policyholders of the Metropolitan Life Insurance Company lost their lives in automobile accidents while using the streets as pedestrians. Of these, 1,600 or 65 per cent were children and moreover out of every twenty children who died in this way eleven were between 5 and 10 years of age. In the year 1925 measles and scarlet fever combined caused 4,342 deaths in children in 41 states, while automobile fatalities caused 4,166, or almost as many. In that year automobiles killed 4 children to diphtheria's seven. Furthermore deaths of children in automobile accidents are caused almost entirely by the car striking or running over children, while either at play on the streets or while crossing the streets.

This is a condition of affairs which has come about as a result of changing conditions of living and is quite serious enough to demand the attention of health authorities. It would seem that health authorities and health organizations throughout the country should take steps both in the direction of public education and in supporting of legislation which will prevent deaths of this type. The death toll from the automobiles is assuming appalling proportions. It is time for action.

PARENTS ARE INDEED PEOPLE

During the last month or two a series of statements by well-known Canadians concerning the desirability of parent education has appeared in the Public Health Journal. A summary of these statements is now appearing in a group of Canadian newspapers. It is pointed out that few Canadians ever face more important responsibilities than the duties involved in parenthood. Most of us would not think of playing golf, laying a sidewalk or operating a second-hand truck without some careful preparative tuition but we quite blithely assume control over the destinies of members of the next generation with whatever knowledge of the subject we secure by guess or good luck.

There is no doubt that the matter of building up a happier and a better race rests very largely with parents, and that if parents are to

undertake the job of seeing that the children of each generation are progressively better than those of the last something more must be done about it than has been thought of as yet.

The Public Health Journal in co-operation with the Canadian Social Hygiene Council is glad to help to bring the problem to public attention. It is hoped that health officers in various parts of the country will undertake to sponsor in their own localities a movement in the direction of parent education for which there is an obvious need.

Further correspondence on the subject is invited in the hope that as time goes on concrete plans may be evolved which will help to relieve the situation.